County of Riverside Department of Public Social Services
In-Home Supportive Services (IHSS) Public Authority
12125 Day St., Suite S-101, Moreno Valley, CA 92557
Phone: (888) 960-4477
E-mail: IHSSPACOR@rivco.org
FAX: (951) 686-1419

FOR COUNTY USE ONLY

Attach image of government-issued ID here

Home Care Provider Verification of Employment (VOE) Request Form

This form must be completed for In-Home Supportive Services (IHSS) home care provider requesting verification of employment from the IHSS program. Please allow **7 business days** for processing. Multiple inquiries will delay processing. County of Riverside VOE responses are effective for 90 days. Due to processing volume, we do not reissue results or re-verifications within that 90-day period.

Requestor/IHSS Provider Information *(please complete entire form)*

FULL SOCIAL SECURITY NUMBER: _____

PROVIDER FULL NAME: _____

ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP

TELEPHONE NUMBER: _____ ALT TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

Requested Information

NOTE: A new signed form must be completed for each verification of employment request.

For questions regarding verification of employment, contact the IHSS HOME Call Center at 1-888-960-4477

Salary/Income Report

Specify the time frame needed:

From: _____/_____ To: _____/_____
a2y0K ¸ŜHN a2y0K ¸ŜHN

☐ Without Salary/Income Report

REQUESTED RESPONSE METHOD

☐ **Same as Requestor/IHSS Provider Information**

FAX: ( ) _____ - _____

Attention: _____

Company Name: _____

E-mail: _____

VOE will be emailed using a secured site

Reason for Request (Check applicable box):

☐ Self (Personal Record)
☐ Apartment
☐ Housing Authority
☐ Lender
☐ Social Security Administration (SSA)
☐ Employment Development Dept. (EDD)
☐ Dept. of Public Social Services (DPSS) (i.e. Medical, Food Stamps, Cal-Works)
☐ Other (specify): _____

AUTHORIZATION

A signed and dated Request for IHSS Provider Record must be received by the Public Authority before any request is processed. A copy of provider's government issued ID is required with this form. This form can be emailed to ***IHSSPACOR@rivco.org***

I authorize the County of Riverside IHSS Public Authority to release my IHSS employment information.

PROVIDER SIGNATURE: _____ **DATE:** _____